

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0008300</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Elizabeth Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>540 Pleasant Street</u> <u>Elizabeth</u> <u>61028</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>JoDaviess</u>		Officer or Administrator of Provider (Signed) <u>03/12/2002</u> (Date)	
Telephone Number: <u>(815)858-2275</u> Fax # <u>(815)858-2596</u>		(Type or Print Name) <u>James Harkness</u>	
IDPA ID Number: <u>36-265434</u>		(Title) <u>Administrator</u>	
Date of Initial License for Current Owners: <u>07/01/1968</u>		(Signed) <u>03/11/2002</u> (Date)	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>John C. Herting, CPA</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Eide Bailly LLP</u> <u>3999 Pennsylvania Ave., Ste 100, Dubuque, IA 52002</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(563)556-1790</u> Fax # <u>(563)557-7842</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>James Harkness</u> Telephone Number: <u>(815)858-2275, ext. 28</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home# 0008300 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 49/17885

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,885</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>49</u>	TOTALS	<u>49</u>	<u>17,885</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>7,695</u>	<u>9,086</u>		<u>16,781</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,695</u>	<u>9,086</u>		<u>16,781</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.83%D. How many bed-hold days during this year were paid by Public Aid?
38 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Assisted Living FacilityF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐I. On what date did you start providing long term care at this location?
Date started 07/08/68J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	117,724	5,202	3,717	126,643	225	126,868		126,868		1
2	Food Purchase		67,652		67,652		67,652	(4,497)	63,155		2
3	Housekeeping	61,214	8,683		69,897	150	70,047		70,047		3
4	Laundry	25,536	3,094		28,630	50	28,680		28,680		4
5	Heat and Other Utilities			40,668	40,668		40,668		40,668		5
6	Maintenance		13,808		13,808	25	13,833		13,833		6
7	Other (specify):*										7
8	TOTAL General Services	204,474	98,439	44,385	347,298	450	347,748	(4,497)	343,251		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	508,121	23,089	3,733	534,943	1,000	535,943		535,943		10
10a	Therapy										10a
11	Activities	49,785	2,240	1,697	53,722	50	53,772	(2,153)	51,619		11
12	Social Services			1,697	1,697	25	1,722		1,722		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	557,906	25,329	7,127	590,362	1,075	591,437	(2,153)	589,284		16
	C. General Administration										
17	Administrative	51,204		12,135	63,339	25	63,364	(11,593)	51,771		17
18	Directors Fees			6,950	6,950		6,950		6,950		18
19	Professional Services			23,342	23,342	(2,481)	20,861		20,861		19
20	Dues, Fees, Subscriptions & Promotions			34,119	34,119	(26,827)	7,292	(793)	6,499		20
21	Clerical & General Office Expenses	15,368	6,070	5,113	26,551	25	26,576		26,576		21
22	Employee Benefits & Payroll Taxes			166,952	166,952	(17,159)	149,793		149,793		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,775	2,775	2,481	5,256		5,256		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,608	37,608	(6,725)	30,883		30,883		26
27	Other (specify):*										27
28	TOTAL General Administration	66,572	6,070	288,994	361,636	(50,661)	310,975	(12,386)	298,589		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	828,952	129,838	340,506	1,299,296	(49,136)	1,250,160	(19,036)	1,231,124		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Elizabeth Nursing Home

#0008300

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			68,261	68,261		68,261	(34,694)	33,567			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			429	429		429	(429)				32
33	Real Estate Taxes			27,271	27,271	(14,883)	12,388		12,388			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			95,961	95,961	(14,883)	81,078	(35,123)	45,955			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,827	26,827		26,827			42
43	Other (specify):* Assisted Living	77,455	37,193	39,605	154,253	37,192	191,445		191,445			43
44	TOTAL Special Cost Centers	77,455	37,193	39,605	154,253	64,019	218,272		218,272			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	906,407	167,031	476,072	1,549,510		1,549,510	(54,159)	1,495,351			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,342)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(429)	32		10
11	Discounts, Allowances, Rebates & Refunds	(28)	17		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,155)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(8,575)	17		17
18	Fines and Penalties	(2,990)	17		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(301)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(492)	20		28
29	Other-Attach Schedule	(36,847)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,159)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (54,159)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Depreciation - noncare assets	\$ (31,428)	30	1
2	Depreciation - relating to 1985 related party sale	(3,266)	30	2
3	Vending machine income	(2,153)	11	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(36,847)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,497)	0	0	0	0	0	0	0	0	0	0	(4,497)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,497)	0	0	0	0	0	0	0	0	0	0	(4,497)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,153)	0	0	0	0	0	0	0	0	0	0	(2,153)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,153)	0	0	0	0	0	0	0	0	0	0	(2,153)	16
	C. General Administration													
17	Administrative	(11,593)	0	0	0	0	0	0	0	0	0	0	(11,593)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(793)	0	0	0	0	0	0	0	0	0	0	(793)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(12,386)	0	0	0	0	0	0	0	0	0	0	(12,386)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,036)	0	0	0	0	0	0	0	0	0	0	(19,036)	29

Summary B

12/31/2001

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Graves	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	\$ 450	L18,C3	1
2	Ken Haas	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	550	L18,C3	2
3	Ted Krohmer	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	550	L18,C3	3
4	Nancy Walker	Shareholder	Board Member	0.00	0	1.5	0.04	Dir. Fees	1,100	L18,C3	4
5	Carol Rayhorn	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	600	L18,C3	5
6	Darlene Reed	Shareholder	Board Member	0.04	0	1.5	0.04	Dir. Fees	1,200	L18,C3	6
7	Jane Specht	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	800	L18,C3	7
8	Wayne Trost	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	550	L18,C3	8
9	Marvin Wurster	Shareholder	Board Member	0.04	0	1.5	0.04	Dir. Fees	550	L18,C3	9
10	James Harkness	Administrator	Administrator	0.00	51,204	40	100.00	Dir. Fees	600	L18,C3	10
11											11
12											12
13								TOTAL	\$ 6,950		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Alliant Energy Loan		X	Energy efficient lights in N.H.	\$332.00	02/25/00	\$ 18,471	\$ 12,320	03/31/05	0.0301	\$ 429	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$332.00		\$ 18,471	\$ 12,320			\$ 429	9	
	B. Non-Facility Related*												
10	Assisted Living Apts.		X	Finance 1998 Addition		02/03/98	600,000	420,000	02/03/08	0.0758	32,243	10	
11	Assisted Living Apts.		X	Finance 1998 Addition		08/03/98	200,000	80,000	08/03/03	0.0728	7,362	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 800,000	\$ 500,000			\$ 39,605	14	
15	TOTALS (line 9+line14)						\$ 818,471	\$ 512,320			\$ 40,034	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

0008300 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	28,081	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	27,676	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(405)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	27,676	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	27,271	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	10,520	8		
	1997	9,796	9		
	1998	24,387	10		
	1999	28,081	11		
	2000	27,676	12		
				FOR OHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elizabeth Nursing Home COUNTY JoDaviess

FACILITY IDPH LICENSE NUMBER 0008300

CONTACT PERSON REGARDING THIS REPORT James Harkness

TELEPHONE (815) 858-2275, ext. 28 FAX #: (815) 858-2596

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-002-348-06</u>	<u>S25 T27 R2E, PT NE NE</u>	\$ <u>27,663.00</u>	\$ <u>12,793.00</u>
2. <u>07-002-348-03</u>	<u>S25 T27 R2E, PT NE NE</u>	\$ <u>13.00</u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>27,676.00</u></u>	\$ <u><u>12,793.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

25,048

B. General Construction Type:

Exterior

Masonry

Frame

Wood

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1967	\$ 1,055	1
2			1985		2
3	TOTALS			\$ 1,055	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	49	1968	1968	\$ 310,220	\$	33	\$ 4,691	\$ 4,691	\$ 310,220
5		1976	1976	6,079		15			6,079
6		1985	1985		7,957	16		(7,957)	
7									
8									
Improvement Type**									
9	Improvements	1973		1,937					1,937
10	Improvements	1968		90,793					90,793
11	Improvements	1969		1,546					1,546
12	Improvements	1975		2,644					2,644
13	Improvements	1976		2,482					2,482
14	Improvements	1977		7,295					7,295
15	Improvements	1978		7,159					7,159
16	Improvements	1980		6,261					6,261
17	Land Improvements	1986		3,143	165	19	165		2,531
18	Land Improvements	1988		850	57	15	57		807
19	Smoke detectors	1981		603					603
20	Roof	1982		11,430					11,430
21	Windows	1983		5,131					5,131
22	Windows	1984		9,124	507	18	507		8,745
23	Vent control	1985		3,837	202	19	202		3,300
24	Door/Wall guards	1986		1,817	96	19	96		1,510
25	Roof Htr & A/C	1987		5,473	174	31.5	174		2,482
26	Land Improvements	1990		5,345	356	15	356		4,022
27	Windows/Service door	1988		13,337	423	31.5	423		5,704
28	Roof Htr & A/C	1989		8,448	268	31.5	268		3,247
29	Roof (East, West, & North)	1990		49,329	1,566	31.5	1,566		17,357
30	Roof well decks	1992		8,194	260	31.5	260		2,470
31	Remodel computer room	1992		5,872	186	31.5	186		1,767
32	Center structure roof	1996		7,950	204	39	204		1,054
33	So. Wing A/C & Htr. Unit	1997		4,160	594	7	594		2,673
34	Kitchen remodeling	1997		22,802	577	39.5	577		2,597
35	Exterior remodeling	1997		20,031	507	39.5	507		2,282
36	26 Toilets	1997		8,443	1,206	7	1,206		5,428

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 New Nursng Hm hand rail	1999	\$ 8,483	\$ 215	39.5	\$ 215	\$	\$ 752		37
38 Cast Iron tub base	1998	1,482	38	39.5	38		133		38
39 Nursing Hm Addition (Indry & Bus. Office)	1998	97,742	2,474	39.5	2,474		8,660		39
40 Land Improvements - NH	1998	2,258	174	15	174		695		40
41 Landscaping - NH	1999	1,185	101	15	101		273		41
42 Screen door system	1999	425	11	39.5	11		27		42
43 Install 14K BTU Htg & A/C roof top unit	2000	3,824	98	39	98		143		43
44 Energy Efficient Lighting - NH	2000	12,431	319	39	319		465		44
45 Outside Lighting - NH	2000	1,190	31	39	31		45		45
46 Land Improvements - NH	2001	2,290	76	15	76		76		46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)		\$ 763,045	\$ 18,842		\$ 15,576	\$ (3,266)	\$ 532,825		70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 104,163	\$ 15,381	\$ 15,381	\$	Various	\$ 56,516	71
72	Current Year Purchases	30,000	1,622	1,622		9.25	1,622	72
73	Fully Depreciated Assets	189,308	988	988		Various	189,308	73
74								74
75	TOTALS	\$ 323,471	\$ 17,991	\$ 17,991	\$		\$ 247,446	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,087,571	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,833	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,567	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,266)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 780,271	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living Bldg Add'n	\$ 1,088,446	\$ 27,555	\$ 103,334	86
87	Land Improvem'ts - Assisted Living	5,150	396	1,584	87
88	Appliances/Furnishings - Assist. Liv	24,331	3,476	12,165	88
89					89
90					90
91	TOTALS	\$ 1,117,927	\$ 31,427	\$ 117,083	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/2001

A. Building and Fixed Equipment (See instructions.)

N/A

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Ending

Fiscal Year Ending	Annual Rent
--------------------	-------------



9. Option to Buy: ☐ **YES** ☐ **NO** **Terms:** _____*

☐ YES ☐ NO

(Attach a schedule detailing the breakdown of movable equipment)

* If there is an option to buy the building, please provide complete details on attached schedule.

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,480	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	102,161		3
4	Supply Inventory (priced at)	4,123		4
5	Short-Term Investments	243,279		5
6	Prepaid Insurance	5,629		6
7	Other Prepaid Expenses	4,814		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deferred Income Tax Bene.</u>	11,621		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 387,107	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	1,542,226		14
15	Leasehold Improvements, at Historical Cost	149,303		15
16	Equipment, at Historical Cost	347,802		16
17	Accumulated Depreciation (book methods)	(709,032)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,335,574	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,722,681	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,908	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	103,663		29
30	Accrued Salaries Payable	90,892		30
31	Accrued Taxes Payable (excluding real estate taxes)	667		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,676		32
33	Accrued Interest Payable	31,603		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 278,409	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	408,656		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Income Taxes</u>	11,044		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 419,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 698,109	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,024,572	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,722,681	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,041,615	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,041,615	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,943)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(11,100)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (17,043)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,024,572	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,518,589	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,518,589	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,153	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,342	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	28	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,523	23
D. Non-Operating Revenue			
24	Contributions	3,962	24
25	Interest and Other Investment Income***	11,479	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,441	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,538,553	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	347,298	31
32	Health Care	590,362	32
33	General Administration	361,636	33
B. Capital Expense			
34	Ownership	95,961	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37		154,253	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,549,510	40
41	Income before Income Taxes (line 30 minus line 40)**	(10,957)	41
42	Income Taxes	5,014	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,943)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,760	1,760	\$ 27,372	\$ 15.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,277	6,738	99,942	14.83	3
4	Licensed Practical Nurses	6,464	6,920	91,366	13.20	4
5	Nurse Aides & Orderlies	28,179	29,838	289,441	9.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,995	2,149	16,877	7.85	9
10	Activity Assistants	1,278	1,369	11,066	8.08	10
11	Social Service Workers	2,127	2,295	21,842	9.52	11
12	Dietician					12
13	Food Service Supervisor	2,265	2,433	25,658	10.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,792	11,480	92,066	8.02	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,196	20,127	9.17	17
18	Housekeepers	4,862	5,096	41,087	8.06	18
19	Laundry	3,341	3,571	25,536	7.15	19
20	Administrator	2,080	2,080	51,204	24.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,473	1,581	15,368	9.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Assisted Living</u>	6,222	6,720	77,455	11.53	33
34	TOTAL (lines 1 - 33)	81,173	86,226	\$ 906,407 *	\$ 10.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	72	\$ 3,717	C3,L1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	108	2,896	C3,L10	39
40	Physical Therapy Consultant	18	690	C3,L10	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	1,697	C3,L11	44
45	Social Service Consultant	45	1,697	C3,L12	45
46	Other(specify)	3	147	C3,L10	46
47					47
48					48
49	TOTAL (lines 35 - 48)	291	\$ 10,844		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	182	\$ 7,292	C3,L19	50
51	Licensed Practical Nurses				51
52	Nurse Aides	185	3,683	C3,L19	52
53	TOTAL (lines 50 - 52)	367	\$ 10,975		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description	Amount	Description	Amount				
James Harkness	Administrator	0.00	\$ 51,204	Workers' Compensation Insurance	\$ 14,160	IDPH License Fee	\$				
				Unemployment Compensation Insurance	6,613	Advertising: Employee Recruitment	3,085				
				FICA Taxes	58,504	Health Care Worker Background Check (Indicate # of checks performed 15)	180				
				Employee Health Insurance	56,601	Promo Public Relations	743				
				Employee Meals		IHCA dues	2,749				
				Illinois Municipal Retirement Fund (IMRF)*		State of IL Franchise Tax	85				
				Employee Physicals	423	IL Dept of Profess. Admin. Dues	100				
				Employee Recognition and Educ. Reimb.	1,718	Employee Drug Screening	300				
				Pension (401K) Plan	11,774	Elizabeth Chamber of Comm.	50				
						Less: Public Relations Expense	(301)				
						Non-allowable advertising	(0				
						Yellow page advertising	(492)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,499			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount			
Creative Mgmt Resources			\$ 8,575			\$	Out-of-State Travel	\$			
IDPH - fine regarding nsg issues			2,990								
Annual dinner expenses			409								
Other admin. Expenses			161				In-State Travel	2,775			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount								
Eide Bailly LLP	Audit/Acctg		\$ 5,660								
Vincent Roth & Toepfer	Legal Fees		3,386								
Temporary Services	Temp. Nsg. Services		11,815								
Seminar Expenses	Tuition/Books		2,481					Seminar Expense 2,481			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL				Entertainment Expense (
			\$ 23,342					(agree to Sch. V, line 24, col. 8)			
								TOTAL	\$ 5,256		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

STATE OF ILLINOIS

0008300

Report Period Beginning: 01/01/2001

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA Dues \$2,749
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 9.25
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,827
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,342
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eide Bailly LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

ELIZABETH NURSING HOME #8300**Y/E 12/31/01****COST REPORT ADJUSTMENTS:**

1) To off-set nonpatient meals (G/L #0331)	<u>2,342</u>	L2,C7
2) To off-set feasibility study for clinic project (abandoned)	<u>8,575</u>	L17,C7
3) To off-set compliance fine from IL Dept of Public Health	<u>2,990</u>	L17,C7
4) To off-set misc. income	<u>28</u>	L17,C7
4) To off-set sales tax on food for non-PA resident days		
NH food costs <u>67652</u> X 6.25% X <u>9,086</u> Non-PA days =	<u>2,155</u>	L2,C7
1.0625 16,781 Total days		
5) To off-set non-allowable Advertising, Public Relations, etc:		
Public relations	251	
Elizabeth Chamber of Comm. Dues	<u>50</u>	
	<u>301</u>	L20,C7
6) To off-set yellow page advertising	<u>492</u>	L20,C7
7) To off-set vending machine income (G/L # 0332)	<u>2,153</u>	L11,C7
8) To deduct building depr. (stems from 1985 related party sale of the Nursing Home)	<u>3266</u>	L30,C7
9) To off-set depreciation noncare assets (assisted Living)	<u>31,428</u>	L30,C7
10) To off-set interest expense due to excess borrowing	<u>429</u>	L32,C7

ELIZABETH NURSING HOME**#8300****Y/E 12/31/01****COST REPORT RECLASSIFICATIONS:**

		<u>From</u>	<u>To</u>
1) Reclass Uniform payments - Total = 1,650:	225	L22	L1
	150	L22	L3
	50	L22	L4
	25	L22	L6
	1000	L22	L10
	50	L22	L11
	25	L22	L12
	25	L22	L17
		L22	L21
	<u>75</u>	L22	L43
	1625		
2) Reclass IDPA Participation Fees - Total = \$26,827		L20	L42
3) Reclass certain unassigned expenses to Assisted Living Facility:			
Property taxes	14,883	L33	L43
Health Insurance	5,526	L22	L43
Workers Comp. Insurance	2,558	L22	L43
Pension (401K) Plan	1,950	L22	L43
Other Insurance	6,725	L26	L43
Payroll taxes	<u>5,475</u>	L22	L43
	<u>37,117</u>		
4) Reclass seminar expenses to Line 24 - Total = \$2,481		L19	L24